Commonwealth of Massachusetts
Group Insurance Commission
P.O. Box 8747, Boston, MA 02114

GIC Retiree Dental Enrollment and Change Form

PLEASE TYPE OR PRINT CLEARLY

01

Insured's GIC-ID (usually Soc. Sec.#)	Sex	Date of Birth	(For Municipal use only) Agency/Division #
— —	Male ☐ Female ☐	____/____/____	—

Name: Last First M.I.

Address (Number and Street) This is a new Address: ☐

City	State	Zip Code	Home Phone No.
			( )

02 NEW ENROLLMENT ☐ CHANGE ☐ CANCEL COVERAGE ☐

Effective Date: / / **Type of Coverage:** Individual ☐ Family ☐ Date of Retirement / /

PLEASE READ CAREFULLY: Important Coverage and Eligibility Notes

- **If you don't sign up for coverage when you are first eligible, you will not be able to enroll until the next annual enrollment period.**
- **If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin. If you sign up for individual or family coverage and decide to cancel, you can never rejoin the plan.**

SPOUSE/DEPENDENT INFORMATION

CHECK ONE: ☐ **NEW MEMBER** ☐ **ADDITION** ☐ **DELETION** ☐ **CORRECTION**

List below all family members, including your spouse, who will be covered under your dental plan. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. Attach separate sheet if additional space is required. Coverage for children ends at age 19; to continue their coverage, complete and return to the GIC a Dependent Ages 19 to 26 Enrollment Form. The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, legal separation, divorce decree, or certificate of appointment as legal guardian for each person you list as a dependent.

Last Name	First	M.I.	Relationship	Date of Birth	Sex	Social Security Number (required)

Reason for addition or deletion: _____ Effective date: _____

Deduction and Coverage Authorization: I authorize my pension authority to deduct from my pension check the amount required for the dental coverage I have selected. If I am a survivor on direct bill, I understand that I will be billed quarterly for this coverage.

X_____ _____
Signature of Applicant Date

FOR GIC USE ONLY

Entered	Verified	Cross Ref. #